

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005038	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/19/2013
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 520 S 7TH ST VINCENNES, IN 47591		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 30405 Facility Number: 005038</p> <p>Type of Survey: State Licensure Off Site JCAHO Accreditation Survey</p> <p>Date of JCAHO On Site Survey - Hospital full survey April 16-19, 2013</p> <p>Date of ISDH off site review - July 31, 2013</p> <p>Reviewer/Surveyor - Deborah Franco RN, PHNS</p> <p>Based on review of the April 16-19, 2013 JCAHO Accreditation Survey Report, it has been determined that Good Samaritan Hospital meets the requirements for Hospital Licensure in Indiana.</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE